Filing TRICARE Standard Claims for Retirees and Their Dependents in the Philippines

It's Important to Fill Out A Claim Form Correctly
The TRICARE claims processing contractor for the overseas regions receives thousands of claims every day. These claims are computer-processed to facilitate reimbursement for TRICARE-covered medical procedures and services. Any mistake, forgotten signature, or other missing information can slow down your claim because the contractor may deny your claim for lack of needed information.

Which Claim Form to Use
TRICARE beneficiaries complete and submit the **DD Form 2642** claim form for reimbursement for care received. As a TRICARE beneficiary you may obtain a copy of this form on the Internet at http://www.tricare.osd.mil/claims/Dd_2642.pdf. You can also get forms from the TRICARE Area Office – Pacific by email at tpao.csc@oki10.med.navy.mil, or phone at (81) 6117-43-2036. Additionally, you can request the claim form from the TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.

Complete the Claim Form
It is important to provide all relevant information regarding the patient and care provided. Although not an exclusive list, the below items are highlighted as they are critical to efficient processing of your claim:

Box 1: Patient's Name
Enter the Patient's last name, first name and middle initial as it appears on the military ID card. Do not use nicknames.

Box 2: Patient's Telephone number
Enter the patient's daytime telephone number and evening telephone number to include the area code.

Box 3: Patient's Address
Enter the complete address of the patient's place of residence at the time of service.

Box 4: Patient's relationship to Sponsor
Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., former spouse.

Box 5: Patient's Date of Birth
Enter the Patient's date of birth.

Box 6: Patient's Sex
Check the box for either male or female patient.

Box 7: Is Patient's condition
Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury-Possible Third Party Liability CHAMPUS." The form may be obtained from the claims processor, Health Benefits Advisor or TRICARE Management Activity.

Box 8a: Describe Condition For which Patient Received Treatment, supplies, or Medication:
Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident.

Box 8b: Was Patient's Care
Check the box to indicate where the care was given.

Box 9: Sponsor's Name
Enter the Sponsor's last name, first name and middle initial as it appears on the military ID card. If the sponsor and patient are the same, enter "same."

Box 10: Sponsor's Social Security Number
Enter the Sponsor's Social Security Number (SSN).

Box 11: Other Health Insurance Coverage
By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Box 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.
NOTE: All other health insurances except Medicaid and CHAMPUS supplemental plans must pay before CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to the CHAMPUS claim.
** The CHAMPUS claims processor cannot process claims until you provide the other health insurance information.

Box 12: Signature of Patient or Authorized person Certifies correctness of Claim and Authorizes Release of Medical or other insurance information
The Patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Box 12a and sign the claim. Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.

Reimbursement Currency and Method of Payment
Beneficiary reimbursement will be in U.S. dollars. If reimbursement is to be in a currency other than U.S. dollars please indicate the reimbursement currency on the top right-hand corner of the DD Form 2642. Due to U.S. Federal law, reimbursement cannot be provided in the form of electronic funds transfer (EFT).

What Goes in Along with the Claim?
Send a fully itemized bill and all **receipts** with your DD Form 2642. If they are not provided to the TRICARE claims processor when needed, your claim could be denied or delayed. So read this section very carefully.

All attachments should be sent in with each claim, even if a claim was previously filed for similar services during the same course of treatment.

- **Fully Itemized Bills**

A fully itemized bill—on the provider's stationary—that shows the cost for each service or supply provided.
It must show the following:

1. Name of the patient
2. Diagnosis or description of symptoms
3. Each item of service or supply
4. Place of service
5. Doctor's or provider's name/address (the one that actually procided your care).
6. Date of care
7. Charge for each item of service or supply

Bills for prescription drugs must be on the pharmacy's letterhead or billing form, and must also show the following:

1. Name of the drug
2. Strength of the drug
3. How much of the drug you bought (the number of pills or amount of other medicine)
4. Cost of each drug (except prepaid prescription plans)
5. Prescription number and date prescription was filled (you should also include a copy of the actual prescription that was written out by your doctor)
6. Name and address of the prescribing doctor
7. Name and address of the pharmacy

Where to Submit Claims Forms
Submit all documentation and completed and signed claim form(s) to the following address:

Wisconsin Physician Services (WPS) – Foreign Claims
P.O. Box 7985
Madison, WI 53707-7985 USA

> ***NOTE:*** *Claims must be submitted via mail; they cannot be submitted by fax or any other electronic means due to signature-validation requirements. Therefore, take ever precaution to ensure that your claim reaches WPS.*

Timely filing requirements:

All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. If a claim is returned for additional information, it must be resubmitted by the filing deadline, or within 90 days of the notice—whichever date is later.

For additional information, you can register online with WPS at http://www.tricare4u.com/. Once you have registered you'll be able to view patient **Eligibility** and amounts paid toward deductibles. Perform a quick **Claim Search** for: status, amount paid and **Explanation of Benefits (EOB).** Registered providers can **Contact Customer Service** using our secured system.

If you have questions about processing or the status of a claim--and you chose not to register with WPS online--you may call:

WPS Claims Customers Service:	1-(608) 301-2310 / 2311
TRICARE Area Office – Pacific:	(81) 611-743-2036
TRICARE Area Office-Pacific email:	tpao.csc@oki10.med.navy.mil